STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 88430-001**

v

Humana Insurance Company
Respondent
_____/

Issued and entered
this 29th day of April 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 12, 2008, XXXXX, on behalf of her minor daughter XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On March 19, 2008, after a preliminary review of the material submitted, the Commissioner accepted the request.

The issue here can be decided by applying the terms of the Petitioner's certificate of insurance (the certificate), the contract that defines her health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner is covered by a group medical policy underwritten by Humana that was effective on July 1, 2007.

On November 18, 2007, the Petitioner experienced an emergency and had to be taken by XXXXX to the XXXXX Hospital. XXXXX was not in Humana's network of providers. Humana processed the claim for the ambulance service and paid $133.47 of the total charge of $746.90, leaving the Petitioner responsible for the balance of $613.43.

The Petitioner appealed Humana's decision. After she completed Humana's internal grievance process, Humana issued a final adverse determination dated February 6, 2008, upholding its decision on the claim.

III
ISSUE

Did Humana correctly process the claim for the Petitioner's ambulance service on November 18, 2007?

IV
ANALYSIS

There is no dispute in this case that emergency ambulance service was required. The issue is whether Humana correctly processed the claims for the service. The Commissioner finds that it did.

Emergency ambulance service is a covered expense under the terms of the Petitioner's certificate. The certificate explains the coverage (page 35):

> *We* will pay benefits for *covered expenses* incurred by you for professional *ambulance* service to, from or between medical facilities for *emergency care*.
>
> *Ambulance* service for *emergency care* provided by a *non-network* provider will be covered at the *network provider* benefit percentage, subject to the *maximum allowable fee*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill you for charges in excess of the *maximum allowable fee*. You may be required to pay any amount not paid by us. [Italics in original]

Thus, Humana will cover emergency ambulance service at the network provider level even if it is provided by a non-network provider as it was here. However, Humana will only cover up to its maximum allowable fee for the service. "Maximum allowable fee" is defined in the certificate:

> ***Maximum allowable fee*** for a *covered expense* is the lesser of:
>
> - The fee charged by the provider for the service;
> - The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the service;
> - The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us;
> - The fee based upon rates negotiated by us or other payors with one or more network providers in a geographic area determined by us for the same or similar services;
> - The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
> - The fee based on a percentage determined by us of the fee Medicare allows for the same or similar services provided in the same geographic area.
>
> **Note:** The bill you receive for services from non-network providers may be significantly higher than the maximum allowable fee. In addition to deductibles, copayments and coinsurance, you are responsible for the difference between the maximum allowable fee and the amount the provider bills you for the services. Any amount you pay to the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible. [Underlining added]

In this case, Humana's maximum allowable fee (MAF) for the Petitioner's ambulance service was $398.30. According to Humana, the MAF was derived from an analysis of a database of actual claims and fees charged for the same service in the geographic area.

The Petitioner has an annual individual network deductible[1] of $250.00 (see page 11). The deductible must be met before Humana makes its payment. Ambulance services are also subject to a 10% copayment by the Petitioner after the deductible has been met (see page 19).

This table shows how Humana processed the claim for the ambulance service:

A	B	C	D	E	F	G	H
Service Code	**Provider Charge**	**Humana's Maximum Allowable Fee (MAF)**	**Amount Not Covered (B – C)**	**Applied to Deductible**	**Coinsurance (10% of C - E)**	**Amount Paid by Humana**	**Petitioner's Responsibility (D + E + F)**
A0427-Advanced Life Support	$602.00	$324.80	$277.20	$250.00	$7.48	$67.32	$613.43
AO425-Mileage	144.90	73.50	71.40		$7.35	66.15	
Totals	$746.90	$ 398.30	$348.60	$250.00	$14.83	$133.47	$613.43

Because XXXXX is a non-network provider, under the terms of the certificate the Petitioner is responsible for the amount in column D (the difference between the provider charge and Humana's MAF) plus the deductible (column E) and coinsurance (column F). After applying the $250.00 network deductible, Humana paid 90% of the difference between its MAF and the deductible. If XXXXX had been a network provider, it would have accepted Humana's MAF as payment in full. The claim would still have been subject to the deductible and coinsurance, but the Petitioner would not be responsible for the difference between the provider's charge and the MAF.

The Petitioner's mother says that the 911 operator who dispatched the ambulance did not ask whether it was a network provider and she says she did not think about it either -- she was understandably focused on the health and safety of her daughter who was bleeding on the chin after collapsing. The Petitioner's mother also says that the nearest network ambulance was 30 miles away. However, there is nothing in the certificate which would require a different

[1] Even though HVA was a non-network provider, Humana, as required by the certificate, applied the $250.00 network deductible instead of the $500.00 non-network deductible.

result. It is the network status of the provider that is critical here, not the fact of the emergency or the availability of network providers. Humana would not be required to pay more than it did even if no network ambulance service had been available at all.

The Commissioner finds that Humana has correctly processed the claims for the non-network services the Petitioner received during her emergency transport on November 18, 2007.

V
ORDER

The Commissioner upholds Humana Insurance Company's February 6, 2007, final adverse determination.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.